U. S. ARMY CHAPLAIN CENTER AND SCHOOL
FT. WADSWORTH
STATEN ISLAND, NEW YORK

AN INTERPERSONAL COMMUNICATION SKILLS APPROACH TO THE TREATMENT OF ALCOHOLISM

D. W. SHEA
C-22
Group 4

Interpersonal Communication is no doubt the most pervasive and significant of any of the communication arenas currently known and studied. The reason for this is that it is within this arena that most, if not all, meaningful relationships are formed and maintained. For example, husband-wife, mother-son, employer-employee, brother-sister, are all close interpersonal relationships and are noted in all societies.

The possible combinations of such relationships are virtually indeterminable, thus substantiating the pervasiveness and significance of the interpersonal arena. Having noted the many interpersonal relationships which may be formed, the importance of an interpersonal communication approach to the treatment of alcoholism takes on a new importance, especially in view of the statement made by Fox in which she defines alcoholism as being both an addiction and a behavioral disturbance in which the excessive use of alcohol interferes with the physical and/or mental health of the individual. It is usually accompanied by a disturbance in the interpersonal relationships within the family, work life, and social environment.[1]

Much has been done in various treatment and rehabilitation programs to alleviate much of this interpersonal disturbance via drugs, group therapy, psychotherapy, and aversion therapy. Little, however, has been done in the interpersonal communication arena which bears the bulk of the problems of the alcoholic, whether drinking or abstinent. This study is an attempt to assess the significance of such an interpersonal approach to the treatment and rehabilitation of alcoholic

patients by means of introducing an Interpersonal Communication Skills Program as part of the treatment process.

It has long been recognized by those dealing with the treatment and rehabilitation of alcoholics that a primary problem lies in getting the alcoholic to participate in follow-up therapy after discharge from the treatment center. Bowen and Androes found in a follow-up study of 79 alcoholics that about one in five patients who participated in treatment at a V.A. hospital made a successful post-hospital adjustment and about one in four of those who completed the program remained abstinent.[2]

Pokorny, Miller and Valles in a follow-up interview with 122 alcoholics found that one year after participation in weekly group sessions on an outpatient basis, 91 of the patients never attended the sessions and if they did, did so far less than 8 times; only 31 attended the sessions 8 or more times; 53% of the latter and 15% of the former were still abstinent after one year. Relapse was found to be less among those who attended the sessions.[3]

In all treatment centers, some type of follow-up therapy is suggested upon discharge. Moore and Buchanan in a nationwide survey of treatment techniques discovered that 82% of the follow-up care rested in the hands of Alcoholics Anonymous (A.A.) in the majority of hospitals and those individuals not receptive to A.A. were left to fend for themselves.[4] Chafetz identified the crucial problem in the outpatient treatment of alcoholics when he reported that 73% of his

patients dropped out before 3 visits.[5] Pokorny et al. further showed that hospital treatment for the alcoholic is only the first step in a program of his integration into society and that rehabilitation efforts must be continued after discharge, if possible with A.A.[6]

In a related follow-up study of discharged alcoholics at the Sheridan, Wyoming Treatment Center, the best prognosis was given for alcoholics who showed enthusiasm for the program, ability to change, and utilization of A.A. aftercare.[7]

As various studies show, in typical rehabilitation programs, follow-up therapy with A.A. is crucial. Often, however, the A.A. follow-up contacts are not made. This led to the belief that perhaps one of the reasons for this follow-up failure is due to the fact that the alcoholic perceives the new group outside the treatment center as threatening to him. This has been substantiated by Sethna and Huntington in their study of a group of patients who lapsed from group psychotherapy. They found that the threat of active participation in group therapy in which the patient is expected to reveal inner thoughts, feelings, and past experiences presented a threat to them, so they lapsed.[8] From this, then, followed the thesis that perhaps by teaching alcoholic patients various interpersonal communication skills, a stepping stone could be provided for the patient to go from the treatment center to the A.A. group or group therapy, and function in the world as it is outside the protection of the hospital.

Alcoholics Anonymous, the aftercare prescribed by a

majority of hospitals and treatment centers, is a fellowship in which men and women share their experiences, strength and hope with each other that they may solve their common problem and help others recover from alcoholism.[9] The A.A. philosophy is centered around its "Twelve Steps", which essentially call for an admission of the disease, belief in a higher power, a personal moral inventory, making amends to persons harmed, helping other alcoholics, facing the problem, doing something about it, and accepting responsibility for one's behavior.

There are various types of A.A. meetings, the most common of which is the "Step Meeting" and "Discussion Meeting."[10] In the former, a chairman gives his views on the particular step in relation to his life and his sobriety. Each member is then called upon to do the same and may either speak or "pass" at his option. In the latter, a similar format is followed only the topic for the meeting is open and each member relates how he feels about a given idea, experience, or value. Each member shares his views with the group, again at his option. A topic may or may not be chosen for this type of meeting.

One aspect which is stressed in A.A. is sharing---experiences, feelings, views, ideas. This follows, no doubt, from the fact that when one speaks, one is in essence convincing himself further of the concept of which he speaks. Anderson states that the most important long-range effect upon a source is that his participation in a communication continually conditions his patterns of behavior, personality, and

self-image to a significant degree.[11] In essence, the source is changed by virtue of the fact that he spoke.

In the A.A. setting when a member speaks, one of two things occur: (1) His views are confirmed by the other members by way of agreement or pats on the back, or (2) he is told in a non-threatening manner that he is wrong or at least misled in his thoughts on the given topic. This mild group pressure causes him to reconsider his views regardless of whether he wants to or not.

When a member does not speak or share at meetings, he is left with his own thoughts, be they good or bad, and his growth is restricted. This is substantiated by Wenburg and Wilmot when they state that the expression of thought creates new thoughts and that we are susceptible to change as a direct result of our own behavior.[12]

Aside from A.A., group therapy is the most effective type of treatment for the alcoholic.[13] It is similar to A.A. in that there is almost immediate identification and mutual support, which makes the alcoholic feel immediately accepted. The group represents a nonthreatening, socially rewarding, yet challenging atmosphere in which their problems can be discussed.

Aversion treatment of alcoholics consists of several methods, ranging from electrical shock[14] to chemically produced aversion in which the patient is administered emetine or apomorphine which produces vomiting within 7 or 8 minutes.[15] The use of disulfiram (antabuse) is a medication

given orally which interferes with the metabolism of alcohol so that even one drink will cause a toxic reaction of a shocklike nature.[16]

The Buchanan et al. study, however, determined that in the majority of state hospitals the most widely used treatment device was A.A. (88%), followed by group psychotherapy (78%), chemotherapy (76%), individual psychotherapy (57%), and aversion therapy (20%).[17]

A less well known and developed method of alcoholic treatment lies in the area of interpersonal communication training. Soskin compared personality and attitude change after two alcoholism programs, lysergide (LSD) and human relations training.[18] A number of significant changes occurred in both programs. The results were essentially the same, only the LSD program required less time (26 days as opposed to 60 days in the human relations training program). In surveying the nature of the personality changes produced by both types of treatment, the most consistent finding was that feelings of psychic discomfort were substantially reduced. The alcoholic was less disturbed by depression, guilt, anxiety and tension after both treatments. The human relations training program was a modification of the HRTL program developed at the Houston, Texas V.A. hospital for psychiatric patients.[19] It was based on the assumption that the alcoholic is deficient to cope with environmental problems, particularly in the area of interpersonal skills.

The program depended heavily on prepared exercises and

was designed to improve sensitivity in interpersonal communication. It also emphasized such principles as interpersonal communication and the use of feedback techniques so that the individual could learn how his behavior affects others. Three basic teaching methods were employed. First, lectures were given on how to increase the effectiveness of groups and on the kinds of effects people have on each other. Second, laboratory exercises were conducted to highlight characteristics of group and individual problems. Third, ratings of self and group were used to evaluate progress.

The use of interpersonal skills per se in the treatment of alcoholics appears to be severely limited; however, the use of such skills and their effectiveness have been borne out in several other areas. Arbes and Hubbell developed a structured Communication Skills Workshop for college students because many of their clients presented problems concerning inefficiency in interpersonal skills. The areas most frequently cited as problematical were the inability to establish interpersonal relationships with one or more people, feelings of inadequacy in relating to the opposite sex, and feelings of anxiety in group settings. They employed five methods in the process of facilitating change: Structure, self-disclosure, feedback, behavior change goals, and intimacy.

Results of pre and post FIRO-B (Fundamental Interpersonal Relations Orientation-Behavior), CSAS (Concept Specific Anxiety Scale), and IRRS (Interpersonal Relationship Rating Scale) showed that on the pre-tests control and experimental

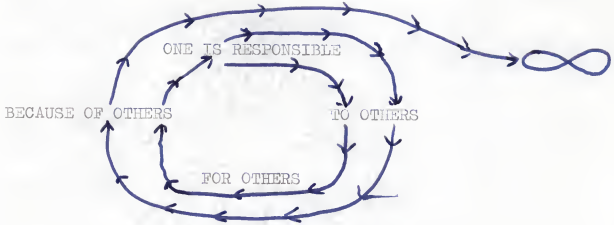
groups differed in only three variables whereas on the post-test they differed on fourteen variables. All changes were in a positive direction for the skills treatment group. The workshop participants perceived themselves as being more aware of the feelings of others, expressing their thoughts more clearly, more willing to discuss their thoughts and emotions with others, being more influential, and more willing to establish new interpersonal relationships.[20]

Interpersonal communication is defined in the present study as being those concepts and skills which enable people to deal with ordinary communication problems that occur in family and work groups, between parent and child, husband and wife, and employer and employee.[21] It also stresses the notions that each depends upon the other for his identity in the given situation.

Cooley points out that communication is a matter of self-preservation, because without expression thought cannot live. The mere fact that man has the need to communicate implies that he also has the potential to communicate.[22] May states that if any organism fails to fulfill it potentialities it becomes sick; for example, if it never walks, the legs soon atrophy. Similarly, if man does not fulfill his potentialities as a person, he becomes sick.[23] This, May claims, is the essence of neurosis.

Maslow states that every human being carries within his own life what he terms the "actualization of self-hood," in which each is capable of satisfying his deepest needs.[24]

However, in order to guarantee the satisfaction of his deepest needs, he must be concerned with the need-satisfaction of others.[25] This implies a systemic view of communication depicted in the following diagram in which each component or person feeds upon the other, affects and is affected by the other, ad infinitum.



This lends itself to the systemic approach to alcoholism in which alcoholism is viewed as a symptom of a complex interactional process. Drinking is a circular, self-perpetuating process which is maintained to preserve homeostasis.[26] Perhaps the interpersoanl communication skills approach, once taught, can likewise become a circular self-perpetuating response in the behavioral repertoire of the recovering alcoholic, and can help him get the "spiral" headed in a different direction.

Notes

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7. Milan Tomsovic, "A Follow-up Study of Discharged Alcoholics," Hospital and Community Psychiatry, 21 (March, 1970), pp. 94-97. Cited from Psychological Abstract, 46, 5171.

8. E.R. Sethna and J.A. Huntington, "A Study of Patients Who Lapsed from Group Psychotherapy," British Journal of Psychiatry. Vol. 119 (July 1971), pp. 60-61.

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12. J.R. Wenburg and W.W. Wilmot, The Personal Communication Process, (New York: John Wiley and Sons, 1973), pp. 243-244.

13. Fox, p. 773.

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17. Moore and Buchanan, pp. 459-460.

18. Robert A. Soskin, "Personality and Attitude Change After Two Alcoholism Treatment Programs: Comparative Contributions of Lyserside and Human Relations Training," Quarterly Journal of Studies on Alcoholism, 31 (September, 1970), pp. 684-689.

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20. Bill H. Arbes et al., "Packaged Impact: A Structured Communication Skills Workshop," Journal of Counseling Psychology, 20 (July, 1973), pp. 332-337.

21. John Stewart, Bridges Not Walls, (Reading, Massachusetts: Addison-Wesley Publishing Company, 1973), p. 5.

22. Charles H. Cooley, Human Nature and the Social Order, (New York: Schribners and Sons, 1907), p. 68.

23. Rollo May, Man's Search for Himself, (New York: W.W. Norton and Company, 1971), p. 16.

24. A.H. Maslow, "Self-Actualizing People: A Study of Psychological Health," Personality Symposia, (New York: Gruene and Stratton, 1950), p. 29.

25. John H. Brenneke and Robert G. Amick, The Struggle for Significance, (Beverly Hills, California: Glencoe Press, 1971), p. 154.

26. G. Ward and A. Fallace, "The Alcoholic and His Helpers: A Systems View," Quarterly Journal of Studies on Alcoholism, 31 (September, 1970), pp. 684-689.

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